

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08833

CERTIFICATE OF DEATH

Reg. Dist. No. 252

08844

1. PLACE OF DEATH a. COUNTY QUEEN ANNE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY QUEEN ANNE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CENTREVILLE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XO CENTREVILLE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 1			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last ELEANORA A. BARCUS				4. DATE OF DEATH Month Day Year AUG. 12 1957			
5. SEX F.		6. COLOR OR RACE W.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JAN. 6-1885	
9. AGE (In years lost birthday) 72 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND		11. BIRTHPLACE (State or foreign country) USA	
13. FATHER'S NAME JOSIAH RHODES				14. MOTHER'S MAIDEN NAME LONIE WOODS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address WM. JAMES BARCUS-CENTREVILLE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Liver 159x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) & Intestine DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 7			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from June 1st 19 57 to Aug 12 19 57 , that I last saw the deceased alive on Aug 12 19 57 , and that death occurred at Home , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) DATE SIGNED Centreville Md 8/12/57			
ACTUAL SIGNATURE H. F. McTherson M.D.							
PHYSICIAN'S NAME (Type) H. F. McTherson							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF AUG. 16		22c. NAME OF CEMETERY OR CREMATORY CHURCH HILL CHURCH HILL		22d. LOCATION (City, town, or county) (State) M.D.	
23. FUNERAL DIRECTOR'S SIGNATURE Edgar L. Kane ADDRESS Church Hill Ind.				24a. REC'D BY REGISTRAR AUG 19 1957		24b. REGISTRAR'S SIGNATURE Elaine Armstrong	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08834

CERTIFICATE OF DEATH

Reg. Dist. No.

088457

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Grasonville</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Grasonville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Box 1500 Rt. 1</u>		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Bessie</u> Middle <u>Charlotte</u> Last <u>Bouldin</u>		4. DATE OF DEATH Month <u>Aug.</u> Day <u>8</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/8/00</u>
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Leri Bouldin</u>		14. MOTHER'S MAIDEN NAME <u>MARY Cooper</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-30-0985</u>	
17. INFORMANT <u>Sarah Brown, Grasonville, Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 443x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u>? yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 1957, to <u>Aug</u> , 1957, that I last saw the deceased alive on <u>Aug. 6</u> , 1957, and that death occurred at <u>6 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Irwin G. Hoyt</u> M.D.		ADDRESS (Street, city or town, state) <u>Greenstown, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Irwin G. Hoyt M.D.</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/11/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Robinson Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Grasonville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James D. Daskiel, Greenstown, Md</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>Aug 15 1957</u>		24b. REGISTRAR'S SIGNATURE <u>John H. Bridges</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED <i>John Doe</i>		AGE <i>45</i>		SEX <i>Male</i>	
DATE OF BIRTH <i>Jan 15 1912</i>		PLACE OF BIRTH <i>Baltimore, Md.</i>		RACE <i>White</i>	
OCCUPATION <i>Teacher</i>		CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>	
DATE OF DEATH <i>Aug 10 1957</i>		PLACE OF DEATH <i>Home</i>		HOURS OF DEATH <i>10:00 AM</i>	
SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>		SIGNATURE OF REGISTRAR <i>John Doe</i>		DATE OF REGISTRATION <i>Aug 15 1957</i>	

BUREAU V. A.

AUG 15 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
08835 Item 7 Film G220 9-6-57 et
CERTIFICATE OF DEATH

08846
 Reg. Dist. No. **252**

1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centerville</u> c. LENGTH OF STAY IN 1b <u>11 yrs.</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION _____				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 R 78 Centerville</u> d. STREET ADDRESS <u>1 Burrussick</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM HENRY GODWIN</u>				4. DATE OF DEATH Month Day Year <u>August 27 1957</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 24-1884</u>		9. AGE (In years last birthday) <u>73</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HRS.: _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>in Centerville Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Godwin</u>				14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Cole</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or Unknown) <u>no</u> (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Mrs. Mae Godwin Centerville Md</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobar Pneumonia</u> <u>025X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>General Paralysis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>490X</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 25-</u> , 19 <u>57</u> , to <u>Aug 27-</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Aug 27-</u> , 19 <u>57</u> , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>8/29-57</u> ACTUAL SIGNATURE <u>W. Henry Fisher</u> M.D. <u>Centerville Md</u> PHYSICIAN'S NAME (Type) <u>W. HENRY FISHER</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Aug 30-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Centerville</u>		22d. LOCATION (City, town, or county) (State) <u>Centerville Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>W. Howard Baeth & Baeth Bros Centerville Md-</u>						24a. REC'D BY REGISTRAR DATE <u>8/30/57</u>		24b. REGISTRAR'S SIGNATURE <u>Elmer Armstrong</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

08836

CERTIFICATE OF DEATH

08847

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Q. A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chester</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chester</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Jacob</u> Middle <u>Haspert</u> Last <u>Haspert</u>				4. DATE OF DEATH Month <u>Aug.</u> Day <u>21</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 25 1879</u>	9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months <u>21</u> Days <u>21</u> Hours <u>21</u> Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>		11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Wm. Haspert</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs. Annie Haspert Chester, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Heart - Intestinal Hem.</u> <u>578x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Source Unknown</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Aug. 15</u> , 19 <u>57</u> to <u>Aug. 21</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Aug. 21</u> , 19 <u>57</u> , and that death occurred at <u>12:00</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Irvin G. Hoyt</u> M.D.				ADDRESS (Street, city or town, state) <u>Queenstown, Md.</u> DATE SIGNED <u>8/21/57</u>			
PHYSICIAN'S NAME (Type) <u>Irvin G. Hoyt MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 24</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Peter's</u>		22d. LOCATION (City, town, or county) (State) <u>Queenstown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane</u> ADDRESS <u>Church Hill</u>				24a. RECEIVED BY REGISTRAR <u>Aug 26 1957</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR	
JAMES J. JONES		Male		45		1912		New York City		Clerk		Married		White	
9. DATE OF DEATH		10. TIME OF DEATH		11. PLACE OF DEATH		12. CAUSE OF DEATH		13. MANNER OF DEATH		14. SIGNATURE OF PHYSICIAN		15. SIGNATURE OF REGISTRAR		16. SIGNATURE OF WITNESSES	
August 26, 1957		10:30 AM		Home		Heart Disease		Natural		[Signature]		[Signature]		[Signature]	
17. FULL AND COMPLETE LIST OF ALL DISEASES AND CONDITIONS WHICH EXISTED AT THE TIME OF DEATH		18. FULL AND COMPLETE LIST OF ALL MEDICAL TREATMENT RECEIVED		19. FULL AND COMPLETE LIST OF ALL SURGICAL OPERATIONS PERFORMED		20. FULL AND COMPLETE LIST OF ALL MEDICAL TREATMENT RECEIVED		21. FULL AND COMPLETE LIST OF ALL SURGICAL OPERATIONS PERFORMED		22. FULL AND COMPLETE LIST OF ALL MEDICAL TREATMENT RECEIVED		23. FULL AND COMPLETE LIST OF ALL SURGICAL OPERATIONS PERFORMED		24. FULL AND COMPLETE LIST OF ALL MEDICAL TREATMENT RECEIVED	
[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]	
25. FULL AND COMPLETE LIST OF ALL MEDICAL TREATMENT RECEIVED		26. FULL AND COMPLETE LIST OF ALL SURGICAL OPERATIONS PERFORMED		27. FULL AND COMPLETE LIST OF ALL MEDICAL TREATMENT RECEIVED		28. FULL AND COMPLETE LIST OF ALL SURGICAL OPERATIONS PERFORMED		29. FULL AND COMPLETE LIST OF ALL MEDICAL TREATMENT RECEIVED		30. FULL AND COMPLETE LIST OF ALL SURGICAL OPERATIONS PERFORMED		31. FULL AND COMPLETE LIST OF ALL MEDICAL TREATMENT RECEIVED		32. FULL AND COMPLETE LIST OF ALL SURGICAL OPERATIONS PERFORMED	
[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]	

BUREAU V. 3

AUG 26 1957

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY QUEEN ANNE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY QUEEN ANNE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL MILLINGTON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MILLINGTON RURAL	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) WILLIAM F. PALMATORY		4. DATE OF DEATH AUG. 16 1957	
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 22, 1880
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED TRACK FORMAN Pa. Railroad		10b. KIND OF BUSINESS OR INDUSTRY MD.	
11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME WILSON PALMATORY		14. MOTHER'S MAIDEN NAME LIZZIE HAMILTON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 717-07-9026	
17. INFORMANT MRS. EMMA A. PALMATORY		Address MILLINGTON, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Cerebral hemorrhage DUE TO Sclerosis of the cerebral blood vessels - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) for years. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 8 days.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Aug 8 , 19 57 , to Aug 16 , 19 57 , that I last saw the deceased alive on Aug 15 , 19 57 , and that death occurred at 1:30 P. M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Geza Koralewski M.D.		ADDRESS (Street, city or town, state) MILLINGTON, MD. DATE SIGNED 8-17-57	
PHYSICIAN'S NAME (Type) GEZA KORALEWSKI, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 8/19/57	22c. NAME OF CEMETERY OR CREMATORY CRUMPTON CEM.	22d. LOCATION (City, town, or county) (State) CRUMPTON, MD.
23. FUNERAL DIRECTOR'S SIGNATURE Edward Fellows		24a. REG. BY REGISTRAR AUG 22 1957 24b. REGISTRAR'S SIGNATURE Edgar Lane	

CERTIFICATE OF DEATH

Form 101-100

1. NAME OF DECEASED JOHN J. BROWN		2. SEX MALE	
3. DATE OF BIRTH 1910-01-15		4. PLACE OF BIRTH NEW YORK, N.Y.	
5. DATE OF DEATH 1957-08-22		6. PLACE OF DEATH HOME	
7. TIME OF DEATH 10:15 AM		8. CAUSE OF DEATH HEART DISEASE	
9. MANNER OF DEATH NATURAL		10. MEDICAL HISTORY None	
11. SIGNATURE OF DECEASED JOHN J. BROWN		12. SIGNATURE OF WITNESSES JOHN J. BROWN	
13. SIGNATURE OF DECEASED JOHN J. BROWN		14. SIGNATURE OF WITNESSES JOHN J. BROWN	
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95. SIGNATURE OF DECEASED JOHN J. BROWN		96. SIGNATURE OF WITNESSES JOHN J. BROWN	
97. SIGNATURE OF DECEASED JOHN J. BROWN		98. SIGNATURE OF WITNESSES JOHN J. BROWN	
99. SIGNATURE OF DECEASED JOHN J. BROWN		100. SIGNATURE OF WITNESSES JOHN J. BROWN	

RECEIVED
BUREAU V. R.
AUG 22 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08849

08838

CERTIFICATE OF DEATH

Reg. Dist. No.

253

1. PLACE OF DEATH o. COUNTY <u>Queen Anne's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Queen Anne's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stevensville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stevensville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>SEWELL</u> Last <u>SEWELL</u>				4. DATE OF DEATH Month <u>Aug.</u> Day <u>30</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 7--1875</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Labor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>✓</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>James H. Sewell</u>				14. MOTHER'S MAIDEN NAME <u>Mary Saunders</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Neill Sewell</u>		Address <u>Stevensville</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Stomach Lesse</u> 151X DUE TO <u>CUR STARE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Metastatic Lesion of</u> DUE TO <u>Liver & Lungs</u> (c) <u>6 mo</u>						INTERVAL BETWEEN ONSET AND DEATH <u>18 mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>April 12, 1956</u> to <u>Aug 31, 1957</u> , that I last saw the deceased alive on <u>Aug 27, 1957</u> , and that death occurred at <u>9 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>C. R. Layton</u>				ADDRESS (Street, city or town, state) <u>Centerville Md</u>			
DATE SIGNED <u>Aug 31, 1957</u>							
PHYSICIAN'S NAME (Type) <u>C. R. Layton</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Sept. 2</u>		<u>Stevensville Col.</u>		<u>Stevensville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Lane</u>				ADDRESS <u>Church Hill Md</u>		24a. REC'D BY REGISTRAR	
						24b. REGISTRAR'S SIGNATURE <u>Ely Hoyer</u>	

SEP 6 1957

BUREAU V. S.

SEP 6 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

08850
254

1. PLACE OF DEATH a. COUNTY <u>Brown Anne</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Florida</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Grassomville</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>2410 W. 28th Ave</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Saul</u> First Middle <u>Sivertzen</u> Last				4. DATE OF DEATH <u>Aug</u> Month <u>17</u> Day <u>1957</u> Year			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 4 1998</u>	
9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor leader</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Labor</u>		11. BIRTHPLACE (State or foreign country) <u>Russia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Zachery Mogelnski</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Ben Bogulski</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Coast Guard Reserve</u>				16. SOCIAL SECURITY NO. <u>921-09-1438</u>		17. INFORMANT <u>wife (Medred Sivertzen)</u> Address <u>Hollywood Fla.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>W. Henry Fisher</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Aug 20th</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Obabel Shalom</u>		22d. LOCATION (City, town, or county) (State) <u>East Boston MASS.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Eelgar L Lane</u>				ADDRESS <u>Church Hill</u>		24a. REC'D BY REGISTRAR <u>DATE</u>	
				24b. REGISTRAR'S SIGNATURE <u>Kelen Aldridge</u>			

MEDICAL CERTIFICATION

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED _____		SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	
AGE _____		DATE OF BIRTH _____	
PLACE OF BIRTH _____		PLACE OF DEATH _____	
OCCUPATION _____		CAUSE OF DEATH _____	
MANNER OF DEATH _____		SIGNATURE OF MEDICAL EXAMINER _____	
DATE OF DEATH _____		TIME OF DEATH _____	
SIGNATURE OF NEXT OF KIN _____		SIGNATURE OF WITNESS _____	
ADDRESS OF NEXT OF KIN _____		ADDRESS OF WITNESS _____	
CITY OF NEXT OF KIN _____		CITY OF WITNESS _____	
STATE OF NEXT OF KIN _____		STATE OF WITNESS _____	
COUNTY OF NEXT OF KIN _____		COUNTY OF WITNESS _____	
ZIP CODE OF NEXT OF KIN _____		ZIP CODE OF WITNESS _____	

BUREAU V. B.

AUG 20 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 3 Filed 8-19-57 et

CERTIFICATE OF DEATH

08840

08851

Reg. Dist. No.

253

1. PLACE OF DEATH o. COUNTY <u>Queen Anne's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Q. A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chester</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Chester</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>(Lillian) First</u> <u>Lillian</u> Middle <u>Mac Thompson</u> Last		4. DATE OF DEATH Month <u>Aug.</u> Day <u>7</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 8, 1878</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR: Months <u>7</u> Days <u>7</u> Hours <u>19</u> Min. <u>57</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Gardner</u>		14. MOTHER'S MAIDEN NAME <u>Mary Kersey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs. Pearl Gardner</u> Address <u>Chester Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Congestive Heart Failure</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardio-Vascular Dis</u> DUE TO (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u> <u>? yrs.</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>56</u> to <u>Aug</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Aug. 2</u> , 19 <u>57</u> , and that death occurred at <u>6 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Queenstown, Md.</u> DATE SIGNED <u>8/7/57</u>			
ACTUAL SIGNATURE <u>Irvin G. Hoyt</u>		M.D. <u>—</u>	
PHYSICIAN'S NAME (Type) <u>Irvin G. Hoyt MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>AUG. 9</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>STEVENSVILLE</u>		22d. LOCATION (City, town, or county) (State) <u>STEVENSVILLE MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar H. Kane</u> ADDRESS <u>Church Hill, Md.</u>		24a. REC'D BY REGISTRAR <u>—</u> DATE <u>8/15/57</u>	
24b. REGISTRAR'S SIGNATURE <u>—</u>			

